

Patient # \_\_\_\_\_

## PATIENT HEALTH HISTORY

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

*Please help us by taking the time to complete the following information on this form as accurately as possible. The information obtained on this form will remain confidential and will become part of your patient record. Thank you for your cooperation.*

**CHIEF COMPLAINT:** (Please check the symptoms that you currently have)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Weight Loss/Poor Appetite | <input type="checkbox"/> Rectal Bleeding/Blood in Stool | <input type="checkbox"/> Heart Burn              |
| <input type="checkbox"/> Fever/Chills              | <input type="checkbox"/> Change in Bowel Habits         | <input type="checkbox"/> Hoarseness              |
| <input type="checkbox"/> Abdominal Pain            | <input type="checkbox"/> Nausea/Vomiting                | <input type="checkbox"/> Swallowing Difficulties |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Chest Pain                     | <input type="checkbox"/> Pain with Swallowing    |
| <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Cough                          | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Others not listed _____   |   |  |

**Personal Medical History**

<b>Surgery:</b>	<b>Year:</b>	<b>Details/Complications:</b>
<input type="checkbox"/> Appendectomy	_____	_____
<input type="checkbox"/> Gallbladder	_____	_____
<input type="checkbox"/> Hernia Repair	_____	_____
<input type="checkbox"/> Hysterectomy	_____	_____
<input type="checkbox"/> Intestinal/Abdominal	_____	_____
<input type="checkbox"/> Stomach/Duodenal Ulcer	_____	_____
<input type="checkbox"/> Surgery Not Listed Above	_____	_____
	_____	_____
	_____	_____

<b>Hospitalizations other than surgery:</b>	<b>Date/Hospital</b>
_____	_____
_____	_____
_____	_____
_____	_____

<b>Previous Endoscopies (Colonoscopy, EGD, ERCP)</b>	<b>Date</b>
_____	_____
_____	_____
_____	_____

- Current Medical Problems:**
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis                               | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Anxiety/Depression   |
| <input type="checkbox"/> Cancer, Type: _____                     | <input type="checkbox"/> Crohn's/Colitis  | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Defibrillator/Pacemaker                 | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Gallstones           |
| <input type="checkbox"/> Heart Problems: _____                   | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> High Blood Pressure                     | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Stent Placement: _____                  | <input type="checkbox"/> Sleep Apnea      | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Thyroid Problems                        | <input type="checkbox"/> Prostate         | <input type="checkbox"/> History of H. pylori |
| <input type="checkbox"/> Cervical Pap Date: _____ Results: _____ |   |   |
| <input type="checkbox"/> Other: _____                            |   |   |

\*\*\* **Please complete both sides of this form.** \*\*\*

